BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

ANGELA L. COOK	)	
Claimant	)	
V.	)	
	)	
STATE OF KANSAS	)	Docket No. 1,052,116
Respondent	)	
AND	)	
	)	
STATE SELF-INSURANCE FUND	)	
Insurance Carrier	)	

ORDER

Respondent and its insurance fund (respondent) requested review of Special Administrative Law Judge Jerry Shelor's June 17, 2013 Award. The Board heard oral argument on October 8, 2013. Dennis Horner, of Kansas City, Kansas, appeared for claimant. Mark A. Buck, of Lawrence, Kansas, appeared for respondent.

The Award indicated claimant sustained a 25.33% impairment to the left lower extremity based upon the ratings of Drs. Hu, Prostic and Pazell, as well as a psychological impairment of 35% based upon the rating of Dr. Eyman, for a combined impairment of 42% to the body as a whole. The Award further indicated claimant had a 100% wage loss and an 82% task loss for a 91% work disability.

The Board has considered the record and adopted the stipulations listed in the Award. At oral argument, the parties agreed Dr. Pazell's impairment rating report was not properly in evidence insofar as he did not testify and the parties did not stipulate to the admission of his report. The parties stipulated that claimant sustained a 20% impairment to her left lower extremity based on splitting Dr. Hu's 10% rating and Dr. Prostic's 30% rating. Further, the parties stipulated that claimant had a preexisting impairment of 3% to the left lower extremity. Finally, the parties agreed that the Board, if necessary, may consult and cite the AMA *Guides*[1] (hereafter *Guides*) and the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (hereafter DSM-IV or DSM-IV-TR).

[1] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

ISSUES

Respondent argues claimant's psychological problems are a result of a genetic, physiological deficiency in brain chemistry and not traceable to claimant's physical injury. Based on the stipulations noted above, respondent waived its arguments that Dr. Pazell's rating should have been considered and that claimant had a 3% preexisting left lower extremity impairment, but it nonetheless asserted that such claimed errors show the Award is replete with inaccuracies. Respondent also asserted claimant's depression is a medical condition and is best assessed by physicians, not psychologists.

Claimant maintains the Award should be affirmed.

Claimant is unemployed and has a 100% wage loss. The only task loss opinion based on claimant's physical restrictions is Dr. Prostic's indication that claimant has an 82% task loss. Therefore, if claimant has whole body impairment, she would be entitled to a 91% work disability. Because her physical impairment is limited to her left lower extremity, covered by K.S.A. 44-510d, she can only currently receive a work disability award if she proves whole body impairment due to traumatic neurosis,[2] which would be impairment covered by K.S.A. 44-510e.

The only issue for the Board's review is: Does claimant have impairment from a traumatic neurosis that is directly traceable to her work injury?

FINDINGS OF FACT

Claimant is a 41 year-old woman with a GED. She has a long history of knee problems. While participating in sports in junior high, her left knee began popping out or locking up. Her kneecap would easily dislocate. As a result of a congenital condition, she underwent left knee surgery in 1986, 1991 and 2005. In 1996, claimant had surgery to repair torn cartilage in her left kneecap as a result of a workers compensation injury. She settled such claim based upon a 3% impairment of function to her left lower extremity. Claimant also had one or two right knee surgeries.

Claimant began working for Osawatomie State Hospital as a housekeeper in July 2006. On February 17, 2010, claimant was walking to the break room when she stumbled on a wet floor and twisted her left knee. Claimant alleges both physical injury to her left knee and psychological injury due to chronic pain.

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[2] The term "traumatic neurosis" is a broad legal term and is not a specific psychiatric diagnosis. *Adamson v. Davis Moore Datsun, Inc.*, 19 Kan. App. 2d 301, 308, 868 P.2d 546 (1994).

Physical Injury

Following her work injury, claimant was taken to Miami County Medical Center and then referred to Olathe Occupational Clinic. Conservative treatment failed to provide relief. Lowry Jones, M.D., an orthopedic surgeon, operated on claimant's left knee on May 4, 2010.

Respondent terminated claimant's employment in July 2010. Claimant has made no attempts to find work or seek additional training.

Due to continued pain and discomfort, Dr. Jones recommended pain management. Claimant was referred to Zhengyu Hu, M.D., a board certified physiatrist. Dr. Hu treated claimant, consisting of pain medication, aqua therapy, use of a TENS unit and electrotherapy, from August 30, 2010 through November 1, 2010. Dr. Hu's diagnosis was chronic left knee pain status post surgery. Claimant never complained to Dr. Hu of psychological or emotional symptoms, at least to the best of Dr. Hu's knowledge. Dr. Hu noted he had no reason to dispute claimant's pain complaints. He agreed that "Chronic pain will affect one's emotions."[3]

Dr. Hu recommended restrictions of frequent sitting/standing for comfort and no frequent squatting or kneeling. Dr. Hu rated claimant's impairment at 10% to the lower extremity (which converts to 4% to the whole person) based on the *Guides*. While Dr. Hu acknowledged that claimant may benefit from a stationary bike or aqua therapy, he only recommended continued medication.

On October 7, 2011, claimant was seen at her attorney's request by Edward Prostic, M.D., a board certified orthopedic surgeon. Claimant presented with complaints of swelling, clicking, popping, giving way and pseudolocking of the left knee.

Dr. Prostic noted claimant walked with a pronounced antalgic gait favoring her left lower extremity which is typical in a person with a painful extremity. Dr. Prostic reported a 25° differential in claimant's left knee, which meant she took shorter strides with her left leg. Dr. Prostic indicated it is normal for a person with an altered gait to have low back symptoms, especially if they have preexisting low back degenerative disk disease. He found no evidence claimant was magnifying her symptoms.

Dr. Prostic diagnosed claimant with progressive osteoarthritis of the left knee and recommended a total knee replacement. Dr. Prostic opined claimant's February 2010 knee injury accelerated her need for a knee replacement. While Dr. Prostic does not believe claimant is an ideal surgical candidate due to her weight and depression, he stated she will still need a total knee replacement.

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[3] Hu Depo. at 45.

Dr. Prostic restricted claimant to predominantly sedentary work. Dr. Prostic rated claimant's impairment at 30% to the left lower extremity pursuant to the *Guides*. Dr. Prostic indicated he had not yet provided claimant with an impairment rating for her low back. Dr. Prostic reviewed a task list provided by Mike Dreiling,[4] a vocational counselor, and opined claimant could no longer perform 19 out of 23 tasks for an 83% task loss.

At the April 10, 2012 regular hearing, claimant testified she needs assistance with household cleaning, yard work and moving heavy objects. She is unable to fully straighten her leg, experiences occasional popping when she walks, and has a continuous burning sensation for which she uses a cooling wrap around her knee two or three times a week. Additionally, she has difficulty going up and down stairs, trouble sleeping, and experiences pain with prolonged standing, as well as grinding and popping with prolonged walking.

Psychiatric Condition

Claimant has a prior history of depression for which she was treated and prescribed anti-depressants, including Paxil, Wellbutrin and Prozac. In 1989 or 1990, claimant was hospitalized for 30 days after the birth of her second child and while going through a divorce. About one decade later, in 2000, claimant received mental health treatment after her mother's death. Claimant testified that both of these episodes lasted approximately six or seven months, but she was able to recover and return to normal activities.

Jodie Wood has been a friend of claimant's since 1983, and has always maintained frequent contact with claimant. Ms. Wood testified that although claimant has had difficulty with depression in the past with her divorce and mother's death, claimant was able to work full-time, stay active, and return to normal activities. After claimant was injured in February 2010, Ms. Wood noticed that claimant became a hermit – not wanting to go out, have friends over, or even accept phone calls at times. She indicated claimant expressed to her a feeling of worthlessness.

In January 2011, claimant went on her own to Elizabeth Layton Center for treatment of depression that she attributed to the pain from her work injury. Claimant reported that she had been depressed since 2010, and that this was her third depressive episode.

Claimant was initially seen at Elizabeth Layton Center by Dana Butler, LSCSW, an outpatient clinician, who has a master's degree in social work.[5] Ms. Butler wrote the following "Clinical Summary:"

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[4] Mike Dreiling conducted a vocational assessment of claimant on October 18, 2011.

[5] K.S.A. 2009 Supp. 44-508(i) defines a "health care provider" as "any person licensed, by the proper licensing authority of this state, another state or the District of Columbia, to practice medicine and surgery, osteopathy, chiropractic, dentistry, optometry, podiatry, audiology or psychology." Ms. Butler, a licensed social worker, is not a health care provider. Her opinions are of little assistance or relevance.

> Angela is a 39 yr female who reports increased depression resulting from an injury sustained at work in Feb, 2010. She continues to have difficulty with ambulation and pain and lost job due to not being able to complete duties. She continues to battle with Workman's comp over medical. She lives with her daughter who is attending college and has a boyfriend who travels a lot. She does not ask for financial assistance from him. She is not able to do things she used to do, including exercise and is feeling useless, in constant pain, has problems sleeping, feeling hopeless, fearful, depressed, tearful, feels worthless, has gained wt and is worried about becoming dependent on her children. She has a hx of being Depressed - Postpartum with daughter - while divorcing and when mom passed away. She is now isolating with few friends. Medically she has chronic pain due to knee and back injury, obesity and allergies. Recommendations were to followup with Individual Therapy and Medication services.[6]

Ms. Butler diagnosed claimant with major depressive disorder, recurrent, moderate, and recommended a medical evaluation and medication. Ms. Butler sensed claimant's chronic pain and financial problems caused claimant's anxiety, stress and depression.

Ms. Butler testified that major depressive disorder encompassed more of claimant's symptoms. To diagnose mood disorder due to a general medical condition, there must be a causal relationship between the medical condition and the psychological symptoms through a physiological mechanism. In her opinion, chronic pain exacerbated, but did not cause, claimant's major depressive disorder. Ms. Butler testified that depression is caused by a chemical imbalance in the brain. Not being a doctor, she was unable to state whether a knee injury could cause such a chemical imbalance.

Ms. Butler testified she would not place any restrictions on claimant's ability to work and believes it would be beneficial if claimant could return to work. It was her opinion that claimant will need ongoing treatment for her condition.

Claimant was treated by Barbara Winkleman, D.O., a staff psychiatrist at Elizabeth Layton Center, who prescribed medication for claimant. Dr. Winkleman diagnosed claimant with major depressive disorder, recurrent, moderate. Dr. Winkleman indicated claimant's depressive symptoms of low mood, crying spells, and a feeling of worthlessness were classic signs and symptoms of major depressive disorder.

Dr. Winkleman opined claimant's depressive episode was not triggered by chronic pain because it is common for individuals to have a recurrent episode once they have had a prior episode. Dr. Winkleman testified that while not fully understood, it is believed depression is the result of a chemical imbalance in the brain or "something to do with neurochemicals."[7]

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[6] Butler Depo., Ex. 1 at 19.

[7] Winkleman Depo. at 11-12.

When she last saw claimant, Dr. Winkleman indicated claimant's diagnosis was in partial remission because claimant's symptoms had decreased to a point where claimant no longer met the diagnosis of major depressive disorder. Dr. Winkleman testified she would not place any restrictions on claimant and believed claimant could return to work from a psychiatric standpoint. Dr. Winkleman indicated claimant will more than likely require anti-depressants for years, if not the rest of her life. Dr. Winkleman intended to continue to evaluate claimant every three months.

Claimant was seen at her attorney's request by Stanley Butts, Ph.D., a board certified psychologist, who has worked with chronic pain patients for 36 years. After evaluating claimant in June 2011 and administering multiple standardized tests, Dr. Butts diagnosed claimant with a pain disorder with both psychological factors and a general medical condition, as well as major depressive disorder, single episode, moderate, and a generalized anxiety disorder, both which were the direct result of her February 17, 2010 injury on the job.[8] Dr. Butts testified the diagnosis of major depressive disorder was based on claimant exhibiting "depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others," and "markedly diminished interest or pleasure in all, or most all, activities most of the day, nearly every day." He noted claimant had problems with sleep and feelings of worthlessness.

Dr. Butts' psychological testing indicated claimant was "ruminating over her chronic pain and is experiencing significant emotional distress."[9] He further noted:

> She is demoralized, feels a failure, feels overwhelmed, is isolating herself from others and is passive. She lacks the energy to cope with everyday living, has difficulty making decisions, taking charge and getting things done in everyday life. She sees herself as physically incapacitated with gastrointestinal, head pain, neurological, and cognitive complaints. She feels helpless and hopeless. She is highly anxious. She lacks positive emotional experiences, is pessimistic, lacks interests, lacks motivation, and is very depressed.[10]

Dr. Butts saw "no indication from the psychological testing that this lady is purposefully trying to present herself in a way as to exaggerate how she feels" and "there's no support here for concluding there's any secondary gain."[11]

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[8] Butts Depo., Ex. 2 at 6.

[9] *Id.*, Ex. 2 at 5.

[10] *Id.*, Ex. 2 at 5-6.

[11] *Id.* at 23, see also p. 36.

Dr. Butts opined claimant's prior depressive episodes after childbirth and death of her mother did not meet the definition of major depression. He believed if claimant had a prior major depressive disorder, her episodes would have occurred closer together.

Dr. Butts was clear about his causation opinion:

> Q. Just have one follow-up question. Is there any doubt in your mind that her psychological presentation as she presented to you and as she reflected in her testing, if that's related to the pain she's having in her left knee? Are they related?
>
> A. Is her psychological condition related to the pain in the left knee?
>
> Q. Yes.
>
> A. Quite definitely.
>
> Q. Okay.
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> A. In fact, I see it as the only cause of her psychological disability at this point.[12]

Dr. Butts acknowledged that because of claimant's psychological issues, she perceives pain to be greater than someone without psychological issues.

Dr. Butts consulted the 2nd, 4th and 5th Edition of the AMA *Guides* in arriving at claimant's impairment and believed that they were essentially the same with regard to a chronic pain disorder. Dr. Butts rated claimant as having marked impairment with a corresponding impairment rating of 45% to the body as a whole.

Claimant was seen at respondent's request by Patrick Hughes, M.D., a board certified practicing psychiatrist for 28 years. Dr. Hughes diagnosed claimant with major depressive disorder. Dr. Hughes believed claimant's prior depressive episodes would fall under major depressive disorder because they were significant enough for claimant to seek treatment and take medication.

Dr. Hughes opined claimant's major depressive disorder was not causally related to the work injury. Dr. Hughes testified that major depressive disorder is not caused or triggered by life events but by an inherited gene that causes underfunctioning or underuse of brain chemicals, serotonin and norepinphrine, and "[c]ertainly not by physical injuries or chronic pain."[13] He noted several times during his deposition that the belief that an injury can cause depression and anxiety is an outmoded concept.

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[12] *Id.* at 78-79.

[13] Hughes Depo. at 22.

Dr. Hughes indicated claimant has no psychiatric impairment attributable to the work injury. He provided no restrictions. He observed that claimant had a psychological drive to obtain the legally, societally or family-endorsed secondary gain of being disabled. Dr. Hughes believed claimant was capable of working any job from a psychiatric standpoint.

When claimant testified at the April 10, 2012 regular hearing, she noted that her life was "out of control."[14] Further, she experiences feelings of worthlessness and worries about how she is going to support herself for the remainder of her life. She testified that she cries all of the time and suffers from depression. She noted that she cannot control her feelings because her leg pain never goes away. Her main focus centers on depression and pain.[15]

Claimant was referred for a court-ordered independent medical evaluation with James R. Eyman, Ph.D., in January 2013. Dr. Eyman diagnosed claimant with major depressive disorder, recurrent, moderate severity, and a pain disorder associated with both psychological factors and a general medical condition. It was Dr. Eyman's opinion that both diagnoses were the "direct result" of claimant's work injury.[16]

Dr. Eyman noted that DSM-IV-TR defines a pain disorder with psychological features and a general medical condition as occurring when the person's predominant complaint is of physical pain that is not intentionally produced or faked, and psychological factors are judged to have played a significant role in the onset, severity, exacerbation, or maintenance of the pain. Dr. Eyman summarized his psychological test results as follows:

> Based on the psychological test results, [claimant] is in significant psychological distress with concerns about her physical functioning; seeing her life as significantly disrupted by her physical problems. Her physical state has left her unhappy, with little energy and minimal enthusiasm for life, and considerable concern about her future. She has thoughts about suicide but no specific plan as to how she might kill herself. Thus, she is significantly depressed, discouraged, and withdrawn. She is plagued by stress and worry.[17]

Dr. Eyman criticized the opinions of Drs. Hughes and Winkelman that claimant's psychological problems were unrelated to her injury. He also questioned Dr. Hughes' assertion that claimant was psychologically motivated to be disabled. Dr. Eyman observed that there was no possibility or evidence that claimant was malingering and stated:

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[14] R.H. Trans. at 35.

[15] *Id.* at 59.

[16] Dr. Eyman report (received Mar. 14, 2013) at 6.

[17] *Id.* at 4.

> [Claimant's] primary focus is on her pain that is due to her medical condition as identified by the various physicians involved in her case, and is not "self-generated" but is exacerbated by her depression, thus fitting the DSM-IV-TR definition and making her symptoms of pain a legitimate psychiatric disorder.[18]

Dr. Eyman noted claimant had not had depression between the year 2000 and her 2011 work injury. He therefore concluded that claimant's "work injury is the direct cause of her current psychological problems."[19]

Pursuant to the *Guides,* Dr. Eyman rated claimant as having a moderate impairment. As the 4th Edition does not give percentage impairment for the classes, Dr. Eyman concluded that claimant would have a 35% whole person impairment based upon the 2nd Edition.[20]

Dr. Eyman recommended claimant continue with medication and psychotherapy until she has reached maximum benefit. Based upon claimant's pain and depression, Dr. Eyman felt she would most likely not be able to work every day, may have problems interacting with co-workers, and have difficulty completing job tasks on time.

PRINCIPLES OF LAW

K.S.A. 2009 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends." K.S.A. 2009 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

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[18] *Id.* at 5.

[19] *Id.* at 4.

[20] A health care provider may properly rate a condition based on his or her judgment where the condition is not accounted for in the *Guides*. See K.S.A. 44-510e; *Smith v. Sophie's Catering & Deli Inc.*, No. 99,713, 202 P.3d 108 (Kansas Court of Appeals unpublished opinion filed Mar. 6, 2009), *publication denied* Nov. 5, 2010, and *Kinser v. Topeka Tree Care, Inc.*, No. 1,014,332, 2006 WL 2632002 (Kan. WCAB Aug. 1, 2006). Due to the fact that the Fourth Edition of the *Guides* contains no numerical figures for psychological impairment, it is proper for claimant's impairment to be based on the Second Edition. See *Harrah v. Coffeyville Regional Medical Center*, No. 1,002,341, 2009 WL 1588597 (Kan. WCAB May 26, 2009); *Kinser, supra*; *Bradford v. Manhattan Mercury/Seaton Publishing Co.*, No. 210,583, 2000 WL 973232 (Kan. WCAB June 19, 2000).

K.S.A. 2009 Supp. 44-501(c) states:

> The employee shall not be entitled to recover for the aggravation of a preexisting condition, except to the extent that the work-related injury causes increased disability. Any award of compensation shall be reduced by the amount of functional impairment determined to be preexisting.

An accidental injury is compensable under the Workers Compensation Act even where the accident only serves to aggravate a preexisting condition.[21] The test is not whether the accident causes the condition, but whether the accident aggravates or accelerates the condition.[22] An injury is not compensable, however, where the worsening or new injury would have occurred even absent the accidental injury or where the injury is shown to have been produced by an independent intervening cause.[23]

K.S.A. 44-510e(a) states in part:

> Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d and amendments thereto. The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury. In any event, the extent of permanent partial general disability shall not be less than the percentage of functional impairment. Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein. An employee shall not be entitled to receive permanent partial general disability compensation in excess of the percentage of functional impairment as long as the employee is engaging in any work for wages equal to 90% or more of the average gross weekly wage that the employee was earning at the time of the injury.

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[21] *Odell v. Unified School District No. 259*, 206 Kan. 752, 758, 481 P.2d 974 (1971).

[22] *Woodward v. Beech Aircraft Corp.*, 24 Kan. App. 2d 510, Syl. ¶ 2, 949 P.2d 1149 (1997).

[23] *Nance v. Harvey County*, 263 Kan. 542, 547-50, 952 P.2d 411 (1997).

In *Love*,[24] the Kansas Court of Appeals held:

> In order to establish a compensable claim for traumatic neurosis under the Kansas Workers' Compensation Act, K.S.A. 44-501 *et. seq*., the claimant must establish: (a) a work-related physical injury; (b) symptoms of the traumatic neurosis; and (c) that the neurosis is directly traceable to the physical injury. . . .

"[G]reat care should be exercised in granting an award for [traumatic neurosis] owing to the nebulous characteristics of [such condition]."[25]

Where a worker has impairment to both a scheduled member and a nonscheduled portion of the body, compensation is based on K.S.A. 44-501e.[26]

ANALYSIS

Claimant proved a compensable traumatic neurosis, She proved a traumatic neurosis directly traceable to her work-related physical injury. The Board adopts Dr. Eyman's court-ordered opinion.

Claimant has a 20% impairment to her left lower extremity due to her February 17, 2010 accidental injury. A 20% lower extremity rating converts to being an 8% whole body rating. She has a 3% preexisting left lower extremity impairment that must be deducted from the Award, pursuant to K.S.A. 2009 Supp. 44-501(c). Under the *Guides*, a 3% lower extremity rating coverts to a 1% whole body impairment. Claimant also has a 35% psychological impairment based on the opinion of Dr. Eyman, the court-ordered psychologist. Using the *Guides*' Combined Values Chart, claimant's permanent physical and psychological impairments combine to be 40% to the body as a whole (35% psychological impairment combined with 8% leg impairment equates to 40%), which is reduced to 39% to account for preexisting impairment.

As claimant has impairment to both a scheduled member (leg) and to a nonscheduled portion of the body (psychological), compensation is awarded under K.S.A. 44-510e.[27] Her whole body impairment and at least 10% wage loss entitle her to a work disability award. Claimant has a 91% work disability, but her 1% preexisting impairment reduces the Award to a 90% work disability.

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[24] *Love v. McDonald's Restaurant*, 13 Kan. App. 2d 397, Syl., 771 P.2d 557, *rev. denied* 245 Kan. 784 (1989).

[25] *Berger v. Hahner, Foreman & Cale, Inc.*, 211 Kan. 541, 550, 506 P.2d 1175 (1973).

[26] See *Bryant v. Excel Corp.*, 239 Kan. 688, 689, 722 P.2d 579 (1986).

[27] See *McCready v. Payless Shoesource*, 41 Kan. App. 2d 79, 200 P.3d 479 (2009).

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board modifies the June 17, 2013 Award. Claimant sustained: (1) a 20% impairment to her left lower extremity on account of her February 17, 2010 accidental injury, reduced to 17% because of her 3% preexisting impairment; (2) a 35% whole body psychological impairment; (3) a combined whole body impairment of 39% after accounting for a 1% reduction for preexisting impairment; and (4) a 91% work disability, which is reduced to a 90% to account for her preexisting left lower extremity impairment when it is converted from 3% to the left lower extremity to a 1% whole body impairment.

AWARD

WHEREFORE, The claimant is entitled to 21.14 weeks of temporary total disability compensation at the rate of $270.68 per week or $5,722.18 followed by 8.86 weeks of temporary total disability compensation at the rate of $393.36 per week or $3,485.17 followed by 29.86 weeks of permanent partial disability compensation at the rate of $393.36 per week or $11,745.73 for a 39% functional disability followed by permanent partial disability compensation at the rate of $393.36 per week not to exceed $100,000.00 for a 90% work disability.

As of November 1, 2013 there would be due and owing to the claimant 21.14 weeks of temporary total disability compensation at the rate of $270.68 per week in the sum of $5,722.18 plus 8.86 weeks of temporary total disability compensation at the rate of $393.36 per week in the sum of $3,485.17 plus 163.29 weeks of permanent partial disability compensation at the rate of $393.36 per week in the sum of $64,231.75 for a total due and owing of $73,439.10, which is ordered paid in one lump sum less amounts previously paid. Thereafter, the remaining balance in the amount of $26,560.90 shall be paid at the rate of $393.36 per week until fully paid or until further order from the Director.

IT IS SO ORDERED.

Dated this _____ day of November, 2013.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
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